

Spinal Center Clinics

2921 West Michigan Avenue
Pensacola, Florida 32526
(850) 434-8880

24 East Nine Mile Road
Pensacola, Florida 32514
(850) 479-1333

M.L. Woodruff, D.C.

C.J. Shaeffer, D.C.
B.J. Keenum, D.C.

PLEASE PRINT

Date of appointment: _____

Name: _____ Birth date: _____
Last First Middle

Address: _____ Age: _____ Sex: F _____ M _____
Street

City State Zip

Home Phone #: _____ Cell Phone #: _____

Social Security Number: _____

EMPLOYMENT DATA:

Employer: _____ Address: _____
Or school name

Work Phone: _____ City _____ State _____ Zip _____

MARITAL STATUS: (Please circle one)

Single Married Divorced Separated Widowed

TYPE OF INSURANCE: Health Ins. Automobile Ins. Workman's Comp.

Name of Insurance Company and Address: _____

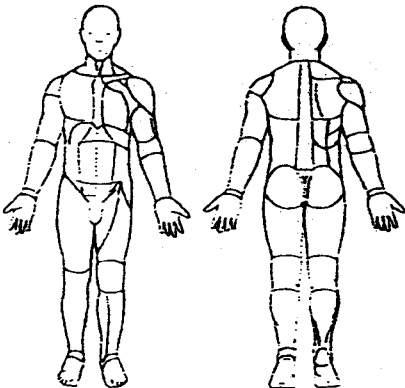
IF THE INSURANCE INFORMATION YOU GAVE US IS NOT IN YOUR NAME, WE NEED THE FOLLOWING:

Whose name is the insurance under? _____

Their address: _____

Their date of birth: _____ Sex M _____ F _____

What is your relationship to this person? _____



If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For ex.: dull, sharp, consistent, off and on, when standing, when sitting, etc.
Where are you hurting, please describe:

Date of Injury/Onset of Symptoms: _____

How did you hurt yourself? Briefly describe: _____

Have you ever had this problem or a similar problem before? _____
Please explain: _____

Have you ever had treatment for this condition? _____
If yes, where, when, and what were your results? _____

Has this problem been getting worse, better, or staying the same? (Please circle one.)

Is there anything you do that makes your condition worse? If yes, what?

Have you ever been in an automobile accident? YES or NO (Please circle)
If yes, please circle approximately when it was.:
PAST YEAR PAST 5 YEARS OVER 5 YEARS

Have you been in any accidents, falls, etc. that might have caused your problem? If yes, explain. _____

PREVIOUS OPERATIONS/SURGERIES:

Type:	Date:
1.) _____	_____
2.) _____	_____
3.) _____	_____
4.) _____	_____

CURRENT MEDICATIONS:

**FEES ARE PAYABLE AT THE TIME X-RAYS, EXAMINATIONS, AND TREATMENT ARE RECEIVED
UNLESS PRIOR ARRANGEMENTS ARE MADE. X-RAYS REMAIN THE PROPERTY OF THIS CLINIC.**

Patient consent for treatment: _____
SIGNATURE

Date: _____

Guardian consent for treatment: _____
(If under 18 years of age) **SIGNATURE**

Nearest Relative Not Living With You: _____
Phone #: _____ Address: _____
Relationship: _____

I will be paying today by: Cash Check
PLEASE CIRCLE ONE